Statement of Nicholas J. Wolter, M.D., CEO
Deaconess Billings Clinic

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Senate Finance Committee Hearing
on

"Medicare Governance:
Perspectives on the Health Care Financing Administration"

Chairman Baucus, Senator Grassley, and members of Senate Finance Committee, I appreciate this opportunity to discuss some of the challenges of working with the Health Care Financing Administration (HCFA), especially at a time when a change in name to the Centers for Medicare and Medicaid Services (CMS) is meant to reflect a commitment to improving working relationships with physicians, hospitals, nursing homes, other providers, and beneficiaries.

I am submitting these comments on behalf of Deaconess Billings Clinic. DBC is a not-for-profit, physician-led, community governed medical foundation serving Montana and northern Wyoming. It is composed of 170 physicians, located at 10 clinic sites, as well as a 272 bed hospital, a nursing home, and a research division. DBC also manages several small hospitals and nursing home facilities in towns with populations of less than 10,000.

DBC, like many other large health care organizations in rural states, serves a very large geographic region with primary, secondary and tertiary care services. It is common for patients to travel 90 minutes to Billings for a primary care visit, and five hours or more for a visit to one of our medical subspecialists. As part of a consortium of rural hospitals, DBC also operates a telemedicine network. DBC's mission is to improve the health of the communities we serve, and to support health care research and education.

I am Dr. Nick Wolter, the CEO of Deaconess Billings Clinic. I have spent most of my professional life practicing critical care medicine and pulmonology, and I still see patients today.

I'd like to start with several simple premises.

- Medicare should support the physician-patient relationship.
- Medicare should encourage quality, coordinated, and efficient care.
- Medicare regulations should be as simple and inexpensive to implement as possible.
- Medicare regulators should work in a cooperative, partnership manner with physicians and other providers.

Deaconess Billings Clinic believes that operating from these premises can provide Medicare beneficiaries, our patients, with the best care and the best value.

Over the past five years, a voluminous number of complex, often confusing regulations, combined with a major increase in compliance and enforcement initiatives, have left health care providers frustrated with Medicare's administration and straining for resources to comply.

One of our experienced directors recently expressed her concern with Medicare regulation and enforcement this way:

> "Something became extremely clear to me at the compliance conference we recently attended. HCFA and the OIG seem to make policy and take a shot gun approach to issues based upon isolated incidents of real problems in healthcare. I've worked for three large integrated systems at this point accounting for nearly 1,000 physicians. I've always been involved in the coding and billing aspects of healthcare, performing audits, appeals, ALJ hearings, etc. In the past 20 some odd years, I have only seen one physician (at another system) who was intentionally non-compliant with the rules of the day. All other issues with billing and coding were related to the fact that the regulations were very difficult to understand and operationalize and too numerous to reasonably keep track of. It seems to me we are adding complex and detailed rules and regulations, plus huge costs for implementation, in order to regulate a tiny minority of physicians and other providers. We're ruling on exception instead of the norm."

The main themes of this testimony are that Medicare regulatory simplification is needed. A more cooperative relationship between the new CMS and providers is needed. More consistency and coordination from the national level are needed, so that providers and beneficiaries in different regions receive more consistent service and policy implementation.

Let me describe some of what has driven DBC, and many other physician organizations, hospitals and other providers, to Congress, asking for regulatory relief and a change in HCFA.

Better Guidance, More Coordination, and More Oversight from the National Level is Needed

Documentation and Coding Guidelines

One of my pulmonology colleagues describes the documentation and coding problem by saying, "I spend as much time producing paper as I do taking care of patients." Medicare pays physicians based upon an incredibly complex set of coding guidelines, dating back to 1992, requiring documentation of services that often do not make sense to the physician in the room trying to take care of the patient. Efforts since 1993 to revise the guidelines have failed to meet the objectives of simplicity and of not interfering in the process of care.

Patients are often also confused. But they cannot tell where accountability rests. Is it with Medicare? Physicians and hospitals? Or is the problem a lack of partnership, coordination, and communication between Medicare and providers?

Example: Preventive Medicine Coding

Let me give you an example of a problem we are facing right now, especially in our internal medicine practices, with coding guidance on preventive medical exam, versus a problem medical exam. Medicare does not generally pay for a preventive exam, the patient does. So this is an area of great patient interest, where clarity is important. Furthermore, preventive exams are common. You would think that the guidance would be clear by now. What we find, however is the following:

- It is very difficult to determine, under current guidance, when a preventive medical exam becomes a problem exam.
- It is also very difficult to determine when a preventive exam becomes *both* a preventive exam *and* a problem exam, during the course of an exam. For instance, if the physician finds a potential heart problem or diabetes, when can billing be done for treatment beyond what would be done in the routine preventive exam? In this instance, we are faced with figuring out the correct billing procedure and making sure we do not charge the Medicare beneficiary for the part of the exam that should be billed to Medicare. This situation is extremely difficult to explain to the patient, even if we could get clear guidance from Medicare.
- Medicare now allows certain preventive tests for women (e.g. a screening pap smear, a breast exam and a pelvic) to be performed and billed to Medicare at the same time as a problem visit billed to Medicare. This is not the case in regards to screening for men. We may bill a preventive screening digital rectal exam to Medicare, but not at the same time as a problem visit billed to Medicare. This is difficult to understand and more difficult to explain to the patient.
- To make this issue even more confusing, we have been faced with differing interpretations from our Carrier and the Medical Director of our Carrier, as well as the Medicare Regional Office on these questions. There are no clear national guidelines in this area and this only perpetuates the confusion.

This month at DBC, we are bringing in a nationally recognized consultant in this area, at significant expense, to educate our physicians and staff on the best understanding we have of current requirements.

Another concern I hear about Evaluation and Management (E&M) Coding, especially from our subspecialists doing consults, is that it does not reward patient counseling. In order to get paid for a high level visit, for asthma or a heart condition, for instance, it isn't enough to thoroughly examine and counsel a patient on that condition, you are required to do a complete history and physical (which has often already been done by their primary care physician), and provide other services that may actually detract from counseling the patient on the condition he or she came to see you about. Effectively physicians face financial incentives to spend less time counseling patients in the areas the patient most needs counseling.

Local Medical Review Policies ("LMRPs"), "Medical Necessity" Determinations, and other Guidance (or lack thereof)

Medicare requires Medicare contractors to decide what is medically appropriate care, within the context of national guidelines. The number of LMRPs varies enormously across the

country by Medicare contractor, and the advice is often inconsistent. The effect is that beneficiary services vary from area to area because of the variations within Medicare administration. Quality may also be inconsistent. Medical evidence should drive Medicare's medical review policies, not variability in the opinions of local Medicare Medical Directors.

Nothing is more difficult for a practicing physician than to be told by the local Medicare Carrier or Fiscal Intermediary that the service he is providing or has authorized is not "medically necessary," especially when that payment denial decision is unsupported by medical evidence.

Example: Air Ambulance

Let me give you one recent, extremely serious example in Montana right now, involving air ambulance services. DBC, like several other hospitals in the state that provide trauma and higher level medical services, owns and staffs an air ambulance. The medical director of that service refers to it as a "flying ICU." We can and do save lives because of air transport. However, for the past several months, our local Medicare Fiscal Intermediary has been denying approximately half of our air transports on the grounds that they were not medically necessary. The denial is accomplished by downcoding to the payment rate for land ambulance. This is happening to other air ambulance programs across Montana, although we understand similar denials are not common with Medicare FIs in other states. Let me give you two examples of denials:

- A 78 year old female sustained a huge intracerebral hemorrhage and was transported by air for neurological evaluation. Vital signs were stable enroute and the patient was confused with slurred speech. Upon neurological evaluation, it was determined by the neurologist that the patient would likely not survive the event. The family made decisions for comfort care and the patient passed away 4 days later. This flight was denied by Medicare, stating that the patient was stable and could have been transported via ground ambulance. Due to the extent of her intracerebral hemorrhage, she could have compromised her airway at any time and did in fact lose consciousness shortly after arriving at DBC. We have appealed this denial.

- A 68 year old male presented to the Emergency Department of a small hospital with chest pain. The patient had an abnormal EKG and elevated cardiac enzymes indicating that he had suffered a heart attack. He was stabilized and transported by air for cardiac evaluation, and was not in active pain during the transport. The admitting cardiologist decided that due to the recent myocardial infarction, it was best to perform cardiac catheterization the following morning. The patient underwent cardiac catheterization within 18 hours of transport and underwent multiple vessel coronary artery bypass later in his hospital stay. This transport was denied based upon the fact that the patient was stable during the transport. The FI stated that the patient must experience chest pain during the transport to establish the medical necessity of air transport. We are appealing this denial based upon the fact that you can never predict which patients will be stabilized and which will continue to evolve and extend their myocardial infarction.

When a physician at DBC certifies an air transport, we believe we are following national guidelines, as well as practicing within the standard of care for a physician for determining when critical care is needed. Our local FI disagrees, requiring an "emergent" condition during transport, and using medical consequences after the time of transport to determine whether the transport was medically necessary. For heart patients, they have told us they look for heart pain during transport to justify medical necessity!

The problem with air ambulance is exacerbated in Montana by the vast distances involved and the absence of professional ambulance services in rural communities. In many communities in rural and frontier Montana, there is, at most, one ambulance, the ambulance is staffed by volunteers, and the ambulances do not provide advanced life support. Therefore, to do what our Medicare FI tells us we should be doing, which is transport the patient by land ambulance with advanced life support capacity, we must send an ambulance from Billings. If the patient is 250 miles from Billings, which is not uncommon, it would require a five hours trip to pick the patient up, then we'd be subjecting the patient to another five-hour trip back. As physicians and air ambulance providers, we cannot, in good conscience, with our patients' interest foremost, justify what our local FI has demanded as a matter of "medical necessity."

It is a terrible dilemma for DBC – we are looking at losing approximately $500,000/year in Medicare denials in the future for our air ambulance program, based upon current denial rates. We know other air transport programs in Montana are considering closing because of Medicare denials.

We believe this problem is due to a lack of coordination and national oversight of Medicare contractors. This leads to major inconsistencies from region to region and FI to FI. It is hard to understand, in cases where medical and expert consensus is available, why such major inconsistencies exist, particularly around issues where quality of care may be significantly compromised. In the case of air medical transport we understand that a national level review was done over a year ago, and that a proposal exists that would address our current problem. We believe more national oversight, expert medical involvement, and the development of consistent policies where medical agreement exists would help address this kind of situation. Even with this approach, much more timely decision-making is necessary.

Example: Ineffectiveness of Dispute Resolution related to disputes with Medicare contractors

Finally, our experience with air ambulance illustrates another problem with Medicare – the ineffectiveness of dispute resolution. Under existing regulations, we have initiated appeals on the approximately 110 denials we received between November 1, 2000, and the end of April 2001. Because our Medicare fiscal intermediary has refused to change its position, we expect to be involved in lengthy and expensive administrative hearings on each claim. The Medicare regional office has not been helpful in trying to resolve the differences in approach between our fiscal intermediary and others in the region. And there is no mechanism that would allow resolution of this issue, as a matter of policy, at a national level.

Other problems with receiving adequate, timely, and consistent guidance from Medicare:

- Last fall, DBC implemented billing for blood products in a timely manner based upon national guidance. Our FI was unable to process the claims when appropriately billed according to national guidance, yet the Medicare clearinghouse through which DBC submits claims electronically (which is owned by our FI) would only accept the claims when submitted as required by the national guidance. We were stuck in a Catch-22, that required manual adjustments to every claim for blood products for several weeks. Our local FI informed us that we were not, in the future, to follow national guidance until it directed us to do so.
- The FI was unable to answer basic questions about billing as a "provider-based clinic," and seemed, from our viewpoint, unable to get adequate assistance from the regional or national level.
- The FI was unable to answer basic questions about implementing the outpatient prospective payment system, and, again, appeared not to receive adequate assistance and information from the regional or national level.

Medicare Rules often Micromanage Care and Direct Physicians How to Practice Medicine and Impose Onerous Paperwork Requirements

A few examples should suffice to demonstrate the problem with overly prescriptive regulations that interfere in the physician-patient relationship:

- Physician Supervision of Diagnostic Tests (Program Memorandum Transmittal B-01-28, issued April 19, 2001). This rule tells physicians, mainly radiologists, 1) when they must "generally supervise" a procedure, which means the procedure is furnished under the physician's direction and control, but their physician presence is not required, 2) when they must "directly supervise, which means they "must be present in the office suite and immediately available," but not in the room, or 3) when they must "personally supervise," which means they must be in the room during the performance of the procedure. The supervision requirement has meant that patients requiring contrasts for MRI must be done under direct supervision of a physician. As a result, patients requiring that procedure frequently must wait for the procedure, sometimes for hours, sometimes for days, raising quality of care concerns. We looked at 10 years of data, and could find no evidence of any safety concerns for patients related to use of contrasts that could not be handled by the highly trained RNs and other staff present, with supervision by radiologists via highly sophisticated technology, that effectively put the physician in the room.
- The recent outpatient prospective payment system rules tell physicians, based upon Medicare's notion of medical necessity, that some procedures will only be paid for by Medicare if done on an <u>inpatient</u> basis. The decision about what is the appropriate care for a specific patient is removed from physician judgement and the physician-patient relationship. Our radiologists can no longer do percutaneous drainage of an abdominal abcess on an outpatient basis, even if the referring physician recommends it. Orthopedists can't decide that low back disk surgery, arm repair with a bone graft, or a single level laminectomy can be done on an outpatient basis, with proper pain management, as is frequently the case for non-Medicare patients.
- The Medicare Conditions of Participation require physicians to physically see an inpatient who is placed under restraints or seclusion within <u>one</u>-hour. This rule has

posed a huge problem for our inpatient Psychiatric Center in terms of staffing and psychiatrist burn-out. While proper oversight of restraints and seclusion is important, this level of micromanagement is not.

We question the need for medical micromanagement of medical judgement through Medicare regulations and the Conditions of Participation. When it occurs, it should be based upon sound medical advice and evidence, not upon individual instances where additional safeguards were needed to prevent a bad outcome.

Examples of rules where we believe the burden to providers outweighs the reason for the rule include the following.

- Advanced Beneficiary Notices. The Medicare requirement to obtain Advanced Beneficiary Notices or ABNs is an extremely difficult operational task. The patient must be notified prior to receiving the service that Medicare does not consider this service medically necessary for his or her condition or will only pay for the service once within a prescribed time period. This requires a huge amount of education to our front line staff who must maintain large binders of all the possible limited coverage services and then must obtain a diagnosis from the doctor and search for the test or tests being ordered to determine if the diagnosis provided is on the list. Then in order to properly bill for this service our fiscal intermediary requires that you submit two bills - one with the covered services and another with the non-covered services. Splitting the bill in this manner is not easily accommodated in most healthcare billing software systems. This problem is made even more difficult when you serve as a reference laboratory and do not ever see the patient on your premises. Even though the lab only receives a specimen, it is still required to ensure that an ABN is acquired for certain tests. Physicians in their private offices experience this as an enormous burden when they are ordering lab tests.
- Medicare Secondary Payor Rules. The Medicare Secondary Payment rules, which received substantial attention during the last Congress, continue to be a significant problem. This rule requires providers to ask 25 questions of Medicare beneficiaries about other payment sources. Initially, this rule required that providers gather this information on every encounter. At DBC, patients will frequently have several encounters in a day. The paperwork burden to DBC and patients, alike, was huge, and actually interfered in the process of care. At this point, our FI requires that we collect such information every two months, which is too frequent. We understand that other FIs still require an MSP questionaire be filled out on every encounter. More reform and more centralized guidance is needed.
- Medicare Cost Report Requirements. We would recommend eliminating the cost report for providers no longer paid on a cost basis, and would substitute the use of Generally Accepted Accounting Principles (GAAP) for financial reporting. At the very least, we believe reducing the size and complexity of the cost report is possible.
- Simplification of other Medicare data requirements. Medicare requires many disparate types of data, in additiona to the cost report. Providers should not be required to keep or provide data unless the new CMS can show it is necessary to carry out its functions, is not otherwise available, and its usefulness is not outweighed by the resources required by providers to gather and provide the data.

Providers everywhere could tell you tales of woe, often involving complex manual processes, and inconvenience and costs to patients, because of these rules. We would like to see the new CMS reconsider the necessity for these rules, and to weigh their costs and the difficulty of implementation against the reason they were adopted. If they could not be completely eliminated, we believe they could be narrowed in scope.

The Volume and Combined Impact of the Rules is Overwhelming

The financial and human resource cost of responding to many of these regulations is becoming clearer to us at DBC and is huge. Staff salaries to support physician coding total $500,000 alone. In addition to trying on an ongoing basis to comply with the regulations discussed above, within the past year, other rules that touch every aspect of DBC operations have been adopted in the following areas:

- HIPAA: Based on expert outside consultation using a conservative approach DBC expects to spend 2.5 million dollars over the next few years complying with Medicare HIPAA rules. We support the intent of many of these rules but hope that simplification of the requirements is yet possible, and that recognition of the practical and financial implications of implementation will be taken into consideration.
- Stark self-referral guidelines, which closely prescribe financial arrangements between physicians and entities: A technical violation of this law -- for instance, failure to have a written contract for a fair market value transaction that otherwise poses no concerns -- carries punitive penalties. For instance, if a DBC physician agrees to train staff on a new outpatient procedure that is going to be done at the facility, and is paid $100, under the Stark regulations, unless he has a written contract with that facility, both he and the facility have violated the law. As a result, the hospital would be precluded from billing Medicare for services that physician refers to that facility, and, if it provided services – allowed procedures to be done on patients by that physician – it would be required to return the money. This would be true even if all of the patients who got the procedures at the hospital needed them, and the physician and hospital were making a special effort to bring the procedures closer to home so people would not have to travel to the bigger hospitals. It is hard to know every time there is a relationship between a physician and an entity that may trigger the Stark rules. The cost of making certain a technical violation of Stark never occurs, for fear of the penalties, is large and unrecognized in Medicare's payments to providers.
- EMTALA: This law, enacted initially as an anti-dumping law at hospital Emergency Departments, is now, by way of HCFA's outpatient prospective payment rules as applied to provider based clinics, extended to every DBC outpatient physician office site in Billings, well beyond the actual property lines of hospitals. Furthermore, providers face a Catch-22 when payment for emergency care is denied by Medicare. We are precluded by EMTALA from asking questions related to the patient's ability to pay when the patient requests emergency services, but we are required to ask precisely those questions (and collect a written ABN from the patient) in order to bill the patient if Medicare denies payment for services provided during emergency treatment.
- Outpatient Prospective Payment System (OPPS): Initiated last August, DBC is still waiting for adequate guidance on some aspects of implementation of these rules. On some issues, like the "pass-through" payments and "inpatient-only" procedures, Medicare dramatically changed the rules, after the effective date, requiring an initial effort to comply, followed quickly by a second effort to comply with changes. The

financial cost to DBC of implementing OPPS is now estimated at $750,000. Furthermore, we do not believe the changes related to OPPS were explained well, and on some issues not at all, to beneficiaries or to secondary payers.

The sheer volume, scope, detail, cost, and rapidity of regulatory changes, combined with substantial penalties for non-compliance, leave health care providers spinning.

Medicare Rules and Payment Inadequacies Create the Following Problems in Rural Areas

Rural physicians, hospitals, nursing homes, and home health agencies currently face enormous challenges. The most recent data collected in Montana for the year 2000 show small health care organizations in our state averaging an operating margin of a negative 6 to 7 percent.

As DBC has become more and more involved in the operation and management of both rural clinics and hospitals, it has become apparent to me that some of the geographic inequities in reimbursement to rural providers contribute to their fragile financial status. These geographic inequities include wage-price index formulas for facilities, a geographic adjustment of work RVUs for rural physicians, other geographic adjustments for both inpatient and outpatient facility services, and the Medicare payment rate for managed care in rural areas which preclude the offering of Medicare+ Choices options. These inequities extend to rural Medicare beneficiaries in at least two ways. First, resources to maintain and develop quality services are less available than in other parts of the country. Second, the beneficiaries themselves may find their own out-of-pocket expenses to be higher, which occurred when the new OPPS was implemented. In Montana significant increases in many hospital outpatient co-pays now exist. We even have co-pays which are higher than the charge itself! Surely increasing the burden on elderly patients in a state with a high senior population and a low per-capita income was not an intended result of the implementation of this complex new program. Let me also note that many Montana health care organizations have chosen to become Critical Access Hospitals, a program piloted in Montana, but severe vulnerability remains.

It is my strong belief that the regulatory and compliance initiatives launched by Congress and by HCFA over the past 5 years will only magnify the problems faced by Montana's rural and frontier physicians and hospitals. Many have negative margins now and do not, in most cases, have the resources to adequately invest in high-quality healthcare delivery infrastructure, much less the infrastructure required to deal with the regulatory and compliance issues we are discussing today. In many cases these physicians and hospitals represent the only access to basic healthcare services for 50, 100 or 200 miles and more. Many of these providers are seeking DBC's help in dealing with these issues, but all are asking why significant geographic disparities are so pervasive in Medicare's programs.

Let me give some specifics as to why these rural issues need urgent attention:

Physician Recruitment. Medicare does not cover the cost of providing physician services in rural areas. Because rural areas also have a disproportionately high Medicare population, the problem is exacerbated by lack of better paying patients to offset the Medicare losses.

Free-standing physician practices are dying because physicians can't make the equivalent of a market income, based on national standards, if they set up in private practice in a rural area. As a result, rural physicians are increasingly employed by hospitals that subsidize their salaries. Part of the reason for this is that Part B reimbursement to physicians in rural areas applies a geographic adjustment to the work component, so that Medicare pays rural physicians less than in other parts of the country. This is difficult for us to understand. In fact, DBC recruiters tell us that we should expect to take at least two years to recruit a primary care physician to small rural towns outside of Billings, and that we will often pay a 10% starting bonus premium. That has been our experience over the past few years. In Montana, if Part B payments for physicians were increased to the national average, it would result in approximately a 2.9% increase in payments. At that level, we would still be subsidizing the salaries of physicians in rural communities, but the burden would be lessened to DBC by approximately $500,000 a year.

Marginal to Negative Operating Margins. MedPAC has begun to identify some of the problems in reimbursement in rural areas. We believe recent MedPAC testimony on the report on rural health care may significantly understate the problem, but the increasing difference in margins between rural and urban hospitals is clear, and should be addressed.

Medical and Administrative Infrastructure. Health care today requires information systems and highly educated, professional staff in order to comply with the deluge of regulations and delivery quality care. There isn't enough money available to build the necessary infrastructure to deliver quality care to rural beneficiaries. Medicare reimbursement to rural hospitals has institutionalized historical, geographical inequities in the level of care provided in rural areas, effectively precluding improvement in the infrastructure. This problem will be magnified by the growing healthcare workforce shortage issues.

Quality and Access. There are very few subspecialists in rural Montana and Wyoming, except via telemedicine and outreach clinics. DBC provides both telemedicine and outreach clinics, and both are subsidized. While recruiting primary care providers is difficult in rural areas; cardiologists, dermatologists, ophthalmologists, gastroenterologists, and so on, don't exist in those areas. Patients, therefore, do not have access, except by virtue of extraordinary efforts, which are not recognized by Medicare payment methodologies. Right now, DBC and other trauma providers are struggling with building a regional trauma network, with no outside funding. Until Medicare addresses these kinds of problems, residents in rural areas will not have the quality of care or access to care that patients have in more urban areas where hospitals and physicians are paid more by Medicare for the same service.

"Patients or Paperwork?"

This is a question and dilemma posed by the American Hospital Association, on behalf of many of its members, including DBC. Physicians are asking the same question. The new Centers for Medicare and Medicaid Services needs to be asking, in a serious way, the same question, and to begin holding meaningful discussions with physicians, hospitals, and other providers about ways to create significant improvement. I encourage your attention to AHA's analysis and recommendations in this area.

Recommendations for Action

1) Simplify coding and documentation standards. Pilot them with practicing physicians without threatened penalties for coding noncompliance.
2) With practicing physician involvement, develop national payment policies, particularly in areas involving frequent services, certain chronic diseases, and critical-care transport where evidence-based information exists to support more standardization. Replace many local medical review policies.
3) Ensure that HCFA provides much improved communication, guidance, interpretation, and clarification to physicians, hospitals, and other providers as regulations are developed and implemented.
4) Improve the supervision, support, and guidance provided to regional offices and FIs and Carriers to significantly reduce the variation and inconsistency in policy, service, and interpretation which exist today.
5) Significantly improve, and make more timely, dispute resolution processes. The current ALJ process is unwieldy, expensive, and ineffective at resolving issues at a policy level.
6) Consider the net effect of the timing and cost of regulatory implementation so that providers are able to balance their resources as they plan their own implementation needs.
7) Eliminate or simplify rules that inappropriately regulate how physicians practice medicine, especially where there is little or no evidence to suggest that they improve quality or safety.
8) Take into account the cost of implementing regulatory and compliance initiatives in reimbursement to physicians, hospitals, and other providers.
9) Adopt the recommendations of the American Hospital Association in its “Patients or Paperwork?” project. Simplify, clarify, and make more practical specific current regulations including OPPS, EMTALA, Stark, data reporting mandates, cost reports, ABN’s, Medicare secondary payor rules, and HIPAA.
10) Address rural inequity issues which threaten facility viability, pay rural M.D.’s a lower work RVU, do not allow for adequate infrastructure investment, impair recruitment and retention of physicians, nurses, and other professionals, unfairly burden Medicare beneficiaries themselves, and do not allow the offering of program options to seniors available elsewhere.
11) Improve communication, service and information to Medicare beneficiaries.

I want to thank Senator Baucus, Senator Grassley, and other committee members for the opportunity to share my observations on current issues facing physicians, hospitals, and other providers as we work with the newly named Centers for Medicare and Medicaid Services, our regional office, and our FI and Carrier to best serve our Medicare patients. Thanks to you all, as well, for your efforts to continually improve a program which has become vitally important to those it has served so well.